G. Administrative Adjustments to Prospective Rates

A nursing home with a prospective rate of payment may apply for discretionary administrative adjustment of the rate for any of the reasons, subject to conditions and limitations, specified in 114.2 CMR 5.12 (see Appendix 1). The Division of Medical Assistance may subsequently assess the need for the facility to remain as a participant in the Medicaid program should the request be denied and it may begin all necessary preparations for transferring publicly-aided patients.

H. Retroactive Adjustments to the Prospective Rates

In general, the prospective rates shall not be adjusted retroactively. However, the Division of Health Care Finance and Policy ***will*** retroactively adjust the prospective rates upwards or downwards under the circumstances described in 114.2 CMR 5.04(9) (see Appendix 1).

III. New Facilities and Major Additions

A. Projected rates for new facilities and Major Additions shall be calculated, using the projected data as described in 114.2 CMR 5.11(1) (see Appendix 1). These rates will remain in effect through 12/31 of the first rate year. For facilities or major additions which become operational after 7/1 of the rate year, the rates will be based on the same projected cost data, but shall remain in effect through the end of the second rate year.

B. Look back rates will be calculated according to 114.2 CMR 5.11(2) or (3) (See Appendix 1) for the period in which the Projected Rates were in effect. Allowable Capital and Other Fixed Costs for New Facilities and Major Additions shall be calculated under one of the methods described in Section II.C.5 herein.

IV. Special Conditions

A. Rate for Innovative and Special Programs

The Division of Medical Assistance ***will*** contract for special and/or innovative programs to meet special needs of certain patients which are not ordinarily met by existing services in nursing facilities. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as a program for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e. Management Minute Category T).

A provider who seeks to participate in an innovative and special program must contract with the Division of Medical Assistance to provide special care and services to distinct categories of patients designated by the Division of Medical Assistance. This is usually done through a Request for Proposals by the Division of Medical Assistance for special or innovative programs to address

special needs of certain patients which are not ordinarily met by existing services in nursing facilities. Reimbursement under the innovative and special programs may be calculated based on the added allowable actual costs and expenses which must be incurred (as determined by the Division of Medical Assistance) by a provider in connection with that program. However, it still must be consistent with the payment methodology established for long-term care facilities. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the Medical Assistance Program, and that such items or services are necessary in the efficient delivery of necessary health care. These costs will be added as an increment to the facility's rate in establishing a rate for an innovative and special program. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

A facility that has recently converted from a facility providing non-acute hospital services to a facility providing nursing facility services may be reimbursed as a special program. In order to be considered as a special program, such a facility must agree to provide, or arrange and pay for, all Medicaid covered services, except hospital services, to all Medicaid recipients that are residents of the facility. The reimbursement to such facilities shall be a per diem rate which shall be the facility's regular case mix rates with an add-on which shall be based on the reasonable costs of providing the goods and services beyond those required to be provided by nursing facilities.

A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

(1) (i) at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board; and,

(2) the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to quality for MM category 10; and,

3) the facility must be a geriatric nursing facility.

B. Facilities that are Converting to Assisted Living Programs.

For facilities that are identified, in writing, by the Division of Medical Assistance for treatment under this provision, the Division of Health Care Finance and Policy shall undertake any and all rate development and certification action as deemed necessary and appropriate after consultation with the Division of Medical Assistance.

C. Information Bulletins

(1) The Division of Health Care Finance and Policy may, from time to time, issue information bulletins interpreting or clarifying provisions of 114.2 CMR 5.00 (see Appendix 1). Such bulletins shall be deemed to be incorporated in the provisions of 114.2 CMR 5.00 and shall be filed with the Massachusetts Secretary of State, shall be distributed to providers, and shall be accessible to the public at the Division of Health Care Finance and Policy's offices during their business hours.

(2) Publicly Aided Patients in Long Term Care Facilities in States Other than Massachusetts

When a publicly aided patient is placed in a long term care facility in a state other than Massachusetts, the Division of Medical Assistance shall pay the per diem rates paid by the state in which the facility is located.

D. Reimbursement of a Receiver Appointed Under M.G.L. c.111 s.72N et seq. (see Appendix 6)

The prospective rates of a facility will be increased by an appropriate per diem amount to provide reasonable compensation to a receiver. Such reimbursement is described in 114.2 CMR 5.12(5)(d) (Appendix 1).

E. Use and Occupancy Allowance for Certain Non-Profit Providers

The per diem rates of non-profit providers, shall reflect the cost of use and occupancy of net allowable fixed assets. Such use and occupancy per diem allowance shall be calculated by the formula and method expressed in 114.2 CMR 5.10(1) (see Appendix 1) and divided by three. This allowance will be added to the calculation of per diem rates of otherwise eligible non-profit providers provided that they have maintained public occupancy of at least seventy percent (70%).

F. Review and Approval of Rates and Rate Methodology By The Division of Medical Assistance

Pursuant to M.G.L.c 118E, s.13 (see Appendix 5) the Division of Medical Assistance shall review and approve or disapprove, any change in rates or in rate methodology proposed by the Division of Health Care Finance and Policy. The Division of Medical Assistance shall review such proposed rate changes for consistency with state policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the Division of Health Care Finance and Policy; provided that, the

Division of Medical Assistance shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the Massachusetts House and Senate Committees on Ways and Means. The Division of Medical Assistance shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the Division of Health Care Finance and Policy together with such recommendations for changes. Such disapproval and recommendations for changes, if any, shall be submitted to the Division of Health Care Finance and Policy after the Division of Medical Assistance is notified that the Division of Health Care Finance and Policy intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the Division of Health Care Finance and Policy regarding such rate change; provided that no rates shall take effect without the approval of the Division of Medical Assistance. The Division of Health Care Finance and Policy and the Division of Medical Assistance shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the Massachusetts House and Senate Committees on Ways and Means.
The Division of Health Care Finance and Policy shall supply the Division of Medical Assistance with all statistical information necessary to carry out the Division's review responsibilities under this Section. Not withstanding the foregoing, said Division of Medical Assistance shall not review, approve, or disapprove any such rate set pursuant to Chapter Twenty-Three of the Massachusetts Acts of Nineteen Hundred and Eighty-Eight.

If projected payments from rates necessary to conform to applicable requirements of title XIX are estimated by the Division of Medical Assistance to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the Division of Medical Assistance and the Division of Health Care Finance and Policy shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Division of Medical Assistance under Title XIX of the Federal Social Security Act.

G. Legislative Mandate for Rate Relief

A nursing home (i) with rate of public utilization, consisting of Medicare, Medicaid and Commission for the Blind patients, of ninety percent or more, (ii) located in the service area of a federally designated sole community hospital, and (iii) with more than 10% of its variable costs and nursing costs disallowed by the Division of Health Care Finance and Policy pursuant to 114.2 CMR 5.00 or any successor regulation, shall have all of its variable costs and nursing costs recognized by the Division of Health Care Finance and Policy and its Medicaid rate adjusted accordingly. The Division of Health Care Finance and Policy shall adjust the prospective rates for any such nursing home that meet the aforementioned criteria for the rates that were effective January 1, 1994 and for each succeeding rate year that such nursing homes comply with aforementioned criteria. The amount of variable costs and nursing costs recognized as allowable by the Division of Health Care Finance and Policy for any rate for a nursing home shall

be limited to an amount that will not increase costs to the Medical Assistance program in an amount greater that three hundred thousand dollars. Not withstanding anything to the contrary contained in this paragraph, in no case shall the provisions of this paragraph apply to any services rendered prior to May 6, 1995.

Any nursing home transferred to a new owner in 1992 shall be entitled to elect to have the costs reported by the prior owner for calendar year 1991 as base year costs for the determination of prospective rates established by the Division of Health Care Finance and Policy under 114.2 CMR 5.00 for rates in effect in 1994 and to use said base year costs for rates any subsequent rate year for which the Division of Health Care Finance and Policy uses 1992 as a base year. The Division of Health Care Finance and Policy shall trend said costs forward for inflation using a cost adjustment factor of nine and fifty-seven hundredths percent (9.57%). The Division of Health Care Finance and Policy shall determine allowable nursing per diem rates by utilizing management minutes by patient by month for all months of the base year. To be eligible to make such an election, any such nursing home transferred in 1992 shall further demonstrate (i) a 1992 public occupancy rate including Medicaid, Medicare and Commission for the Blind patients, in excess for ninety percent (ii) a 1992 occupancy rate in excess of ninety-seven percent (iii) a location within the catchment area of a municipal acute care hospital; and (iv) financing with a section 504 loan, so-called, from the United States Small Business Administration. Not withstanding anything to the contrary contained in this paragraph, in no case shall the provisions of this paragraph apply to any services rendered prior to May 6, 1995.

Any nursing facility that meets either the standards set forth in (a) or (b) below shall have its total acquisition costs allowed as the allowable basis of fixed assets, notwithstanding any limits on the same that appear elsewhere in this State Plan, when the Division of Medical Assistance calculates the facility's reimbursement rates. This provision shall only apply to services rendered on or after June 3, 1995.

(a) 1. the owner purchased the nursing home on or after January 1, 1987;

2. the owner has received a determination letter from the Internal Revenue Service that it is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986;

3. the owner (i) owns a nonprofit hospital (the "Hospital") located within the Commonwealth of Massachusetts which is licensed by the Department of Public Health or (ii) is a nonprofit organization affiliated with a nonprofit hospital which is organized and operated for the benefit of, to perform one or more functions of, or to carry out one or more of the purposes of the nonprofit hospital it is affiliated with, including operation of freestanding nursing homes licensed by the Department of Public Health;

4. the owner's patient population is, on average, not less than eighty-five percent (85%) Medicaid recipients;

5. the Hospital has, on average, not less than eighty percent (80%) occupancy of medical or surgical beds;

6. when the owner purchased the nursing facility (i) the change of ownership did not occur between a person or organization which is associated or affiliated with or has control of or is controlled by the owner or is related to the owner or any director, trustee, partner, shareholder or administrator of the owner by common ownership or control or in a manner specified in section 267(b) and (c) of the Internal Revenue Code of 1986; (ii) the change of ownership was made for reasonable consideration; (iii) the change in ownership was a bona fide transfer of all powers and indicia of ownership and (iv) the change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing, or refinancing:
or

(b) 1. the owner acquired the nursing facility from an acute care hospital to operate the facility pursuant to relief granted to the acute care hospital by the acute care hospital conversion board pursuant to M.G.L. c.6A, s.101;

2. the acute care hospital conversion board approved the owner's acquisition costs of the facility; and,

3. on average, no less than eight-five percent (85%) of the nursing facility's patient population are Medicaid recipients.

Notwithstanding anything to the contrary contained in this State Plan, any nursing home that is owned by the Martha's Vineyard Hospital Foundation during the time that said Foundation also administers a federally designated sole community provider hospital shall have allowed all of its extra variable and fixed costs that reasonably result from such nursing home being located in a geographically isolated area.

Notwithstanding anything to the contrary contained in this State Plan, any nursing home that has over 75% of its residents having a primary diagnosis of multiple sclerosis shall have all of its nursing costs recognized as an allowable cost.

H. Notice of Proposed Rate

At least ten (10) days prior to scheduled Division of Health Care Finance and Policy action certifying a prospective rate for a provider, a notice of the proposed rates and a copy of adjustments to the provider's base-year costs shall be sent to the provider. A provider may comment in writing on the proposed rates and

any adjustments during the period between notice and scheduled Division of Health Care Finance and Policy action. If additional time is required to formulate a written comment, the provider may request in writing a postponement of scheduled Division of Health Care Finance and Policy action. In the case of a preliminary prospective rate determined pursuant to 114.2 CMR 5.04(11) (see Appendix 1), the ten (10) day comment period provided for in this section shall not commence until the Division of Health Care Finance and Policy issues notice of the audited prospective rates.

I. Determination of Reasonable Capital Expenditure for Facilities Building in Urban Underbedded Areas

For the purposes of establishing rates of payment, special provisions, as defined in 114.2 CMR 5.09(2)(C)(2a.) (see Appendix 1), will be utilized to determine Maximum Capital Expenditure for facilities exempt from the Department of Public Health Determination of Need process pursuant to its "Guidelines for Determination of Need Exemptions for long Term Care Beds Constructed in Urban Underbedded Areas".

J. Appeals

1. Statutory Basis

Any provider aggrieved by a rate of payment established pursuant to 114.2 CMR 5.00 et seq. (see Appendix 1) may file an appeal with the Division of Administrative Law Appeals, established under M.G.L. c. 7, s. 4H (see Appendix 3), within thirty (30) calendar days of the filing of any such rate with the state secretary. Appeals hereunder shall be governed by the provisions of M.G.L. c. 6A, s. 36 (see Appendix 4).

2. Standard on Appeal

On appeal, the validity of any rate established for a provider shall be judged solely on the basis of its conformity with the principles governing the determination of rates contained in 114.2 CMR 5.00 (see Appendix 1).

3. Pending Appeal

The pendency of a proceeding or hearing may not be construed to prevent the from redetermining a rate of payment for any reason the Division of Health Care Finance and Policy may consider appropriate under M.G.L. c. 6A, s.s.31-46 (see Appendix 4), and the Division of Health Care Finance and Policy shall have the right to request information pursuant to 114.2 CMR 5.03(6) and 5.04(5) not withstanding the pendency of any such proceeding or hearing. The Provider's rate as determined by the Division of Health Care Finance and Policy under 114.2 CMR 5.00 et seq. (see Appendix 1) shall apply in the meantime.

APPENDIX 2
CASEMIX MANAGEMENT MINUTES CATEGORIES

MANAGEMENT MINUTES CATEGORIES	RANGE OF MINUTES
H	0 - 65
J	65.1 - 85.0
K	85.1 - 110.0
L	110.1 - 140.0
M	140.1 - 170.0
N	170.1 - 200.0
P	200.1 - 225.0
R	225.1 - 245.0
S	245.1 - 270.0
T	270.1 +

State Plan Under Title XIX of the Social Security Act

State: Massachusetts

Institutional Reimbursement

ATTACHMENT 1

114.2 CMR 5.00
Prospective Rates of Payment to Nursing Facilities

The Commonwealth of Massachusetts
Executive Office of Health and Human Services

Division of Health Care Finance and Policy

WILLIAM F. WELD
GOVERNOR

ARGEO PAUL CELLUCCI
LT. GOVERNOR

JOSEPH V. GALLANT
SECRETARY

BARBARA ERBAN WEINSTEIN
COMMISSIONER

February 21, 1997

The Honorable William Galvin
Secretary of the Commonwealth
State House
Boston, MA 02133

Dear Mr. Secretary,

At its meeting on February 21, 1997, the Division of Health Care Finance and Policy voted to adopt amendments to regulation 114.2 CMR 5.00 Prospective Rates of Payment to Nursing Facilities. This regulation is issued pursuant to the Division's authority under M.G.L. c. 118G.

A public hearing was held by the Division on January 21, 1997 with the provisions of M.G. L. c. 118G, to consider proposed amendments to regulation 114.2 CMR 5.00.

Based on a comparison of the estimated rates in effect for 1996 and those estimated for 1997, the increase in Title XIX expenditures associated with these amendments is estimated to be $32 million dollars. However, the total fiscal impact associated with changes in case-mix intensity or utilization during 1997 can not be predicted at this time.

Very truly yours,

John A. Daley
Executive Secretary

Encl.

(617) 451-5330 (Voice) Two Boylston Street Boston MA 02116-4704 (617) 451-1878 (Fax)

OFFICIAL

114.2 CMR 5.00: PROSPECTIVE RATES OF PAYMENT TO NURSING FACILITIES

Section

5.01: General Provisions
5.02: General Definitions
5.03: Reporting Requirements
5.04: Principles for Determining Prospective Rates of Payment
5.05: Nursing Costs
5.06: Director of Nurses
5.07: Variable Costs
5.08: Administrative and General Costs
5.09: Capital and Other Fixed Costs
5.10: Equity and Use and Occupancy Allowance
5.11: New Facilities and Major Additions
5.12: Administrative Adjustments
5.13: Special Provisions

5.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 5.00 governs the rates of payment effective January 1, 1997 for services rendered to Publicly-Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.

(2) Authority. 114.2 CMR 5.00 is adopted pursuant to M.G.L. c. 118G.

5.02: General Definitions

Meaning of Terms. As used in 114.2 CMR 5.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 5.00 are capitalized.

Actual Utilization Rate. The percentage of occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units which may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Base Year. The calendar year or portion of the calendar year used to compute the prospective rates as defined in 114.2 CMR 5.04(2).

Building. The structure that houses residents. Building Costs include the direct cost of construction of the shell and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures that are made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Case-Mix Category. One of ten categories of resident acuity that represents a range of a discrete number of Management Minutes.

Case-Mix Data. The average of the Management Minutes scores submitted by a Nursing Facility to the Division of Medical Assistance during the Base Year .

Case-Mix Group-Heavy. A peer group composed of Nursing Facilities which have an average Management Minutes score for the Case-Mix Data greater than 200 minutes.

Case-Mix Group-Light. A peer group composed of Nursing Facilities which have an average Management Minutes score for the Case-Mix Data from 30 to 200 inclusive.

5.02: continued

Change of Ownership. A *bona fide* transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the facility rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Cost Center. Classification of similar costs, as defined in 114.2 CMR 5.04(1), for the purposes of reporting and auditing costs and establishing rates.

Department. The Massachusetts Department of Public Health.

Desk Audit. A comprehensive audit performed at the Division's offices in which the auditor evaluates the accuracy of the financial and non-financial information in the Cost Reports and supporting documentation in accordance with an audit program.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to such larger items as the Building .

Exit Conference. A conference conducted at the close of an on-site Field Audit at which Division auditors present audit findings and recommendations to the Provider and the Provider may respond to the Division's findings and present additional information for review. The conference may take place at a scheduled meeting or by telephone.

Field Audit. An audit performed on-site at the Nursing Facility in which the auditor evaluates the accuracy of the information in the Cost Reports by examining the books and records of the Facility and evaluating internal controls, observing the physical plant, and interviewing the Nursing Facility staff.

Final Plan. A plan for a substantial capital improvement involving physical changes or alterations to the Nursing Facility that changes the size and/or functions of a room or otherwise requires prior approval and plan review by the Department pursuant to 105 CMR 150.017 (A) New Construction, Alterations and Conversions.

Generally Available Employee Benefits. Employee benefits which are nondiscriminatory and available to all full-time employees.

Hospital-Based Nursing Facility. A separate Unit located in the hospital building licensed for both hospital and Long-Term care services. It does not include free-standing Nursing Facilities owned by hospitals.

5.02: continued

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the facility is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the facility's increased productivity, greater capacity or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, *et seq*.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Long Term Interest Expense. Reasonable and necessary expense incurred for the use of reimbursable loans related to the care of publicly-assisted residents. It includes all the costs of borrowing money, including, but not limited to, interest, mortgage acquisition costs, and mortgage insurance premiums.

Major Addition. A newly constructed addition to a facility which increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A unit of measurement of resident care intensity by discrete care-giving activities, or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the Division of Medical Assistance.

Massachusetts Corporate Excise Tax. Those taxes which have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed bed days for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A facility's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs Those costs (such as finder's fees, points, certain legal fees, and filing fees) that are necessary to obtain Long-Term financing through a mortgage, bond or other long-term debt instrument

5.02: continued

Non-Profit Provider. A Provider either organized for charitable purposes or recognized as a non-profit entity by the Internal Revenue Service. It includes Massachusetts corporations organized under M.G.L. c. 180; tax exempt clubs, associations, organizations, or entities; corporations organized under M.G.L. c. 156B and granted a 501(c)(3) tax exemption; and facilities owned or operated by governmental Units.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, § 71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Nursing Home Reimbursement Area (NHRA). Three distinct geographic areas based upon the following federally designated Health Service Areas (HSAs): NHRA 1 = HSA 1; NHRA 2 = HSA 2 and 5; NHRA 3 = HSA 3, 4, and 6 and used to compute reasonable nursing costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a facility reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Division of Medical Assistance. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Personnel. The following personnel are defined in accordance with the Department's regulations at 105 CMR 150.000 (*Licensing of Long-Term Care Facilities*): Registered Nurse; Licensed Practical Nurse; Nurses' Aide, Nurse's Assistant, Orderlies; Dietitian; Physical Therapist; Occupational Therapist; Speech Pathologist, Audiologist; B.A. Social Worker, M.S.W. Social Worker; Social Worker complying with equivalency standards established by the Department; Food Service Supervisor; Health Service Supervisor; Director of Nurses; Supervisor of Nurses; and Medical Director.

Private Nursing Facility. A Nursing Facility that does not have a provider agreement with the Division of Medical Assistance to provide services to publicly-assisted Residents.

Proprietary Provider. A Provider that does not meet the criteria specified in the definition of "Non-Profit Provider."

Proposed Rates. Rates calculated by the Division which are sent to the Provider for review before certification pursuant to 114.2 CMR 5.13(1).

Provider. A Nursing Facility providing care to Publicly-Aided Residents or Industrial Accident Residents.

Prudent Buyer Concept. The assumption a purchase price which exceeds the market price for a supply or services is an unreasonable cost.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly-Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Rate Year. The calendar year in which the prospective *per diem* rates are in effect.

Reasonable Operating Costs. Reasonable and necessary provider costs incurred to provide care to Publicly-Aided Residents and within the requirements and limitations of 114.2 CMR 5.00. The Division will determine the reasonableness and necessity of any cost by comparison to the cost of providing comparable services and by reference to the Prudent Buyer Concept.

5.02: continued

Related Party. An individual or organization associated or affiliated with, or which has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b), 267(c) and 318 of the Internal Revenue Code of 1954 as amended provided, however, that 10% will be the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility which has been licensed by the Department to provide residential care.

Substantial Capital Expenditure. A capital expenditure which meets the criteria set forth in 114.2 CMR 5.12 for an administrative adjustment to the Rates.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (*Licensing of Long-Term Care Facilities*).

Urban Underbedded Area. An area defined by the Department of Public Health in its Guidelines entitled "Guidelines for Determination of Need exemptions for Long Term Care Beds Constructed in Urban Underbedded Areas."

5.03: Reporting Requirements

(1) Required Costs Reports.

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report contains the facility's claim for reimbursement and the complete financial condition of the facility, including all applicable management company, central office, and real estate expenses.

(b) Realty Company Cost Report. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.

(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it claims management or central office expense. If these costs are claimed for reimbursement, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(2) General Cost Reporting Requirements.

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's claim for reimbursement. Providers must be able to document expenses relating to affiliated entities for which reimbursement is claimed whether or not they are Related Parties.

5.03: continued

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger which clearly identifies each asset for which reimbursement is claimed, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions for which reimbursement is claimed. The Division will not reimburse the salary and fringe benefits of any individual for which the Provider does not maintain a job description and time records.

(e) Other Cost Reporting Requirements.

1. Administrative Personnel and Consultants. Providers must charge the cost of administrative personnel as defined in 114.2 CMR 5.08(1) to the appropriate Administrative and General account .

a. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

b. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Expenses which Generate Income. Providers must identify the expense accounts which generate income. The Division will offset reported ancillary income if the Provider does not identify the associated expense account.

3. Laundry Expense. Providers must separately identify the expense associated with laundry services not provided to all Residents. Providers may not claim reimbursement for such expense.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets which are no longer used to provide care to Publicly-Aided Residents and may not claim reimbursement for the assets.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment , accumulated depreciation, and the accounting entries on the books and records of the facility to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers must not report such expenditures as prepaid expenses.

5. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

6. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services. The Division will limit reimbursement for such goods and services to the Related Party's cost. The Division will not reimburse Related Party salaries or other expenses unless such expenses are disclosed as Related Party payments.

7. Draw Accounts. Providers may not report or claim Proprietorship or Partnership Drawings as salary expense.